Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: MONDAY, 10 OCTOBER 2016 at 3:00 pm

P R E S E N T :

Present:

Councillor Rory Palmer (Chair)	–	Deputy City Mayor, Leicester City Council.
John Adler	–	Chief Executive, University Hospitals of Leicester NHS Trust.
Ivan Browne	–	Deputy Director of Public Health.
Karen Chouhan	–	Chair, Healthwatch Leicester.
Councillor Piara Singh Clair	–	Assistant City Mayor, Culture, Leisure and Sport, Leicester City Council.
Councillor Adam Clarke	–	Assistant City Mayor, Energy and Sustainability, Leicester City Council.
Matthew Cane	–	Group Manager, Leicestershire Fire and Rescue Service
Steven Forbes	–	Strategic Director of Adult Social Care, Leicester City Council.
Andy Keeling	–	Chief Operating Officer, Leicester City Council.
Sue Lock	–	Managing Director, Leicester Clinical Commissioning Group
Superintendent Mark Newcombe	–	Adviser to the Police and Crime Commissioner, Office of the Police and Crime Commissioner.
Councillor Abdul Osman	–	Assistant City Mayor, Public Health, Leicester City Council.

Councillor Sarah Russell	–	Assistant City Mayor, Children's Young People and Schools, Leicester City Council.

Standing Invitees

Toby Sanders	Senior Responsible Officer – Better Care Together Programme

In attendance

Graham Carey	–	Democratic Services, Leicester City Council.

26. APOLOGIES FOR ABSENCE

Apologies for absence were received from:-

Lord Willy Bach, Leicester Leicestershire and Rutland, Police and Crime Commissioner.
Frances Craven, Strategic Director of Children's Services, Leicester City Council.
Professor Azhar Farooqi, Co-Chair, Leicester City Clinical Commissioning Group.
Chief Superintendent Andy Lee, Head of Local Policing Directorate, Leicestershire Police.
Dr Peter Miller, Chief Executive, Leicestershire Partnership NHS Trust.
Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group.
Ruth Tennant, Director of Public Health, Leicester City Council.
Trish Thompson, Locality Director Central NHS England – Midlands & East (Central England)

The Chair stated that there were two changes to the Board's membership as follows:-

a) Matthew Cane – Group Manager Leicestershire Fire and Rescue Service who has replaced Steve Robinson-Day (Collaboration Manager) who has retired.

b) Professor Martin Tobin, Professor of Genetic Epidemiology and Public Health and MRC Senior Clinical Fellow, University of Leicester has resigned from the Board following his appointment as the Director of the newly formed Leicester Precision Medicine Institute.

The Chair welcomed Mr Cane to his first meeting and expressed congratulations to Professor Tobin on his new appointment and thanked him for his contributions to the Board. The Chair would discuss Professor Tobin's replacement on the Board with both Universities.

27. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business to be discussed at the meeting. No such declarations were made.

28. MINUTES OF THE PREVIOUS MEETING

AGREED:

That the Minutes of the previous meeting of the Board held on 18th August 2016 be confirmed as a correct record.

29. SUSTAINABILITY AND TRANSFORMATION PLAN

Toby Sanders, Senior Responsible Officer for the Leicester, Leicestershire and Rutland Sustainability and Transformation Plan gave a presentation to update the Board on the progress with the STP since the last update to the Board at its meeting on 6 June 2016. (Minute 10 refers)

The final Plan was expected to be submitted at the end of October 2016 to NHS England and when it had received approval it would be made available for public consultation.

The key points to note from the presentation were:-

STP Update

a) The Plan addressed local issues and implemented the NHS 5 year forward view to March 2021. It made the case for national/external capital investment and access to non-recurrent transformation funding.

b) It built upon the Better Care Together proposals and showed how sustainability would be achieved. In developing the STP each area has to show how they were going to ensure sustainability in the following areas:-

- Health and Wellbeing
  (Lifestyle and Prevention, Outcome and Inequalities, Mental and Health Parity of Esteem).

- Improving care and quality
  (Emergency Care Pathway, General Practice variation and resilience and clinical workforce supply).

- Ensuring financial sustainability (improving productivity and closing the financial gap)
  (Provider systems and processes [internal efficiency], estates configuration and back office systems).

c) By 2021 current spending across LLR would increase from the current expenditure of £1.6b to £1.8b. However, the increased demand on services and demographic growth, together with the cost of delivering services, was estimated to outstrip available resources by £450m across the NHS and £70m across local authorities.

d) As a result of the STP process and a review of the 'triple aim' gaps (above), there would be focus upon the following five work strands:-

- New models of care focusing upon prevention and moderating demand growth.
  - Urgent and emergency care.
  - Integrated locality teams.
  - Resilient primary medical care.
  - Planned care.

- Service configuration to ensure clinical and financial sustainability.
  - Move acute hospital services to 2 sites (LRI and Glenfield)
  - Consolidate maternity services at the LRI.
  - Smaller overall reduction in acute hospital beds than originally planned.
  - Reduce the number of community hospital sites with impatient wards from 8-6.
  - Move Hinckley day case and diagnostic services from Mount Road to Sunnyside/health Centre.
  - Detailed proposals being developed for community services in Hinckley, Oakham and Lutterworth.
  - Changes subject to external capital investment (c£350m).
  - No decisions taken until after formal public consultation.

- Redesign pathways to deliver improved outcomes for patients and deliver core access and quality.
  - Builds on the work carried out on the BCT work streams and key local access/quality issues involving prevention, long term conditions, cancer, mental health, learning disabilities and continuing healthcare and personalisation.

- Operational efficiencies to reduce variation and waste.
  - Back office efficiencies/reducing corporate overheads.
  - Medicines optimisation – reviews, cost and waste.
  - Best value procurement.
  - Provider system/process efficiencies to reduce delay and duplication.
  - Rostering systems and job planning to reduce use of agency staff.
  - Estate utilisation across the wider public sector.

- Getting the enablers right to create the conditions for success.
  - Patient and public involvement.
  - Clinical leadership.

- Workforce.
- IM&T (Local Digital Roadmaps).
- Estates.
- Integration between health and social care commissioning.
- Organisational development/culture.

e) Once the STP had received assurance from NHS England it would be made public in November. Strengthened governance and delivery arrangements were also planned to be implemented in November. The plan would then be translated into 2 year operational plans and the operational contracts put in place to support the management of services.

f) Public consultation was expected to take place in January 2017.

STP Governance Arrangements

a) New governance arrangements were being designed with a view to simplifying ownership and to increase clinical leaderships and public visibility. It was intended to have dual ownership through both Health and Wellbeing Board and individual NHS Boards.

b) A new System Leadership Team (SLT) was proposed with both clinical and executive membership with individual delegated authority to represent commissioners and providers of services.

c) Greater stakeholder transparency was planned with public meetings and a quarterly forum. Multi agency implementation teams would deliver the priorities with strong patient involvement.

d) Draft proposals would be submitted during October.

STP Patient and Public engagement

a) PPI groups and Healthwatch would be involved in shaping issues and priorities.

b) Most proposals were already in the public domain through BCT and UHL's 5 year plan; and there had already been summary presentations on the STP made in public. The full STP documents would be made available in November 2017.

c) A new System Stakeholder Forum to start in November would provide wider on-going discussion.

d) Communications and engagement would be issued by each partner organisation's communication teams.

The Chair commented that, whilst there were no major surprises in the context of LLR, the various decisions would need very different methods of

consideration, particularly in the political context. He also commented that the issue of BCT branding should be reviewed as it now had negative images from the public resulting from long delays in making plans available for public consultation. He also felt that the Health Needs Neighbourhood Centres would need to be examined in greater detail to assess their impact upon local government services and different areas of the city.

Members in discussing the presentation made the following comments and observations:-

a) There was an apparent paradox as Health and Wellbeing Boards were expected to have system leadership on health issues in their areas but Boards would only receive the STP Plan after it had been given approval by NHS England.

b) The Board should have key role in the process but the complexity of political accountability amongst constituent partners should be recognised and decision making should not be made by the 'STP' as such but by individual constituent partners.

c) The Board was expected to have ownership of the STP and whilst there would be an opportunity to engage with the public and the plans might change as they advance through the process; the Board had not had full and complete details of the STP proposals prior to consultation.

d) Healthwatch should be involved with the System Leadership Team (SLT) and members questioned how patients and the public could be involved in the process.

e) It would be helpful to have a diagram clearly setting out where decisions will be made and whether there will be any public involvement to make the process more transparent compared to the current opaque process.

f) The proposed roles of the Boards in the process would need further clarity around the references to 'ownership' as these would be interpreted differently by different partners in the process.

g) The frustration with the process of the STP delaying the consultation on the BCT was also shared by some health partners and providers.

In response the Senior Responsible Officer stated that:-

a) Patients and the public had an important part to play and this role would be discussed at a meeting later in the week. There was a role for a forum to act as a sounding board on STP issues as they emerged. Patients, carers and families were already closely involved in a number of work stream issues.

b) The current draft STP could be shared with Board members in confidence at this stage if requested.

c) The intention for the SLT was to have all members as full equal members with decision making authority.

AGREED:

1. That the Senior Responsible Officer be thanked for the representation.

2. That the Board recognises its need to play an important role in the governance arrangements for the STP.

3. The Board should have a lead role around the primary care strand of STP.

4. The Terms of Reference for the Board in the Governance arrangements should be submitted to the next meeting of the Board.

30. INFANT MORTALITY STRATEGY

Clare Mills, Lead Commissioner (Healthy Child Programme), Public Health and Nicola Bassindale, Service Manager (Strategy, Quality & Performance), Education & Children's Services presented a report outlining the new strategy to reduce infant mortality in Leicester, Leicestershire and Rutland.

It was noted that the strategy would run from 2016 to 2019 with an associated action log that recorded current and planned actions across a range of risk factors. Progress would be monitored by the LLR Infant Mortality Strategy Group (IMSG) with scrutiny and oversight by the Maternity Services Liaison Committee (MSCL).

The IMSG had identified a number of issues and would meet quarterly to review the progress on the action log and to consider a key issue. The City had higher rates of infant mortality and stillbirths than regional and national rates but was comparable with the comparator group. However, the numbers involved were small and the contributing factors were complex; involving issues such as smoking during pregnancy, maternal obesity, poverty, substance misuse, language barriers and late access to the maternity pathways.

During discussion on the strategy the following comments and observations were made:-

a) The second sentence in Issue 2.3 of the Action Log should read Mothers from Asian or Asian British ethnic groups are reported to have smaller babies.

b) The Young People's Council should be involved in engaging with young mothers.

c) GPs had an important role to play in the process but were not identified within the Action Log. Information should be shared across the whole health system and all involved should be clear about what was expected of them.

d) There were no primary care representatives on the steering group but midwives were involved.

e) There were difficulties in breaking figures down into ethnicity in view of the low numbers involved, as this could potentially identify specific families and well as become statistically unreliable.

The Chair commented that the Board endorsed the general strategy and commented that the quality of information given to parents was inconsistent and there could be a more integrated approach.

AGREED:

That the Board supported the actions and recommendations in the report and the Chair would consider whether the Board would be the appropriate place to receive updates on the progress made with the strategy in the future.

31. FINAL REPORT ON THE DELIVERY OF THE JOINT HEALTH AND WELLBEING STRATEGY (2013-16)

Members received a report that presented final information on progress in delivering the Joint Health and Wellbeing Strategy: 'Closing the Gap'. The responsibility for ensuring effective delivery of this strategy had been devolved to the Leicester City Joint Integrated Commissioning Board (JICB).

The Board was asked to note progress on the delivery of the Joint Health and Wellbeing Strategy and the areas of concern highlighted in the report and the response of the JICB to these (section 3.7).

Measures that had shown particular improvement relative to the baseline in the strategy were:-

Breastfeeding at 6-8 weeks – 62.1% compared to the baseline on 54.9%

Smoking in pregnancy – The decline experienced in 2013/14 has been reversed and the rate of 11.8% in 2014/15 and the early part of 2015/16 shows an improvement on the baseline.

Teenage conception rates - There had been a significant improvement from the baseline.

Diabetes – The Management of blood sugar levels had improved from 62% to 69.7%.

Carers' receiving needs assessments - The 2015/16 data (45.4%) shows an improvement of over 140% from the baseline data.18.8%).

Older people who are still at home 91 days after discharge from hospital into reablement - Performance had improved from 77.2% from the baseline to 91.5% in 2015/6.

Older people admitted on a permanent basis to residential or nursing care The rate of admissions had fallen from 763 per 100,000 to 653 per 100,000 since the baseline was established.

Dementia diagnosis rates - The percentage of patients diagnosed with dementia against the expected prevalence for the population had increased from the 2011/12 baseline of 52% to 88.2% in November 2015.

Measures which had shown deterioration from the baseline in the strategy were:-

Obesity in children in Year Six - The positive improvements through 2009/12 had not been sustained. And the performance in 2014/15 had fallen below the previous 'worst' position in 2009/10. However, the performance remained better than the Council's comparator group average (experiencing a similar decline in 2014/15), but was below the England average. The solutions to this issue were complex and effort continued to address them.

Smoking cessation - 4 week quit rates - The 2014/15 outturn data and year to date information for 2015/16 confirmed previously reported concerns about this measure. This deterioration reflected a national decline in quit rates, largely attributed to limited national marketing, the increased usage of e-cigarettes and the difficulties in reaching / working effectively with entrenched smokers. However, Leicester continued to out-perform its comparator authorities. Leicester had a supportive framework towards the use of e-cigarettes.

Coverage of cervical screening in women - This had been considered as an area of concern by the Board previously. Data published in November 2015 confirmed a year on year decline from the baseline in the strategy. The marked decline in 2014/15 could be attributed in part to a change in recording methodology. The drop in the England average was 4.3% with Leicester experiencing a 4.9% drop. Leicester also continued to under-perform against both the England and our comparator averages. Work continued with Public Health England and National Health England to understand the issues and to consider proposals to address them.

Following comments from Members it was noted:-

a) The improvements in oral health in children under 5 years old was included within the strategy and significant improvements had been made in the last 3 years.

b) The Council was now performing well nationally in relation to reducing

the delays in the transfer of care from hospital to social care.

The Chair welcomed the report and thanked all those that had been involved collectively in the initiatives within the strategy. The Strategy had been about making changes and significant improvements had been achieved through deliberate and targeted decisions and interventions. The scale of progress had generally been pleasing.

AGREED:

The Board noted the progress the delivery of the Joint Health and Wellbeing Strategy and the actions that were planned.

32. ADULTS JOINT STRATEGIC NEEDS ASSESSMENT 2016

The Deputy Director of Public Health presented a report on the progress in updating the Joint Strategic Needs Assessment 2016 (JSNA). The JSNA was predominantly web-based and iterative in nature, with annual reviews of sections planned. It is produced by a multi-agency team overseen by the JSNA Programme Board.

A summary document, Snapshots: Health and Wellbeing in Leicester had been prepared to both accompany the briefings and to promote use of the web pages. The infographics in the Snapshots document would be made available on the web pages for downloading and use in presentations of various types.

The first block of the Adults Section of the JSNA 2016 was in the final stages of delivery and would shortly be on the Council's website. Appendix B to the report listed the topics that would be added later in the year on various Adult lifestyle factors, specific health conditions and specific population groups such as Homeless and Lesbian Gay Bisexual and Transgender. Children and young people's topics were also planned to be added later in the year.

The JSNA was available to social care and health organisations to help inform service provision. The intention was to make the JSNA more of a web based information resource rather than merely a list of tables and statistics. The Snapshots were designed as an accessible way into the JSNA, and the website would also include a series of slides that could be used by anyone for use in presentations and training within their own organisations.

AGREED:

That the progress made to date and the approach taken to make the JSNA more accessible and user friendly be welcomed.

33. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from members of the public present at the meeting.

34. DATES OF FUTURE MEETINGS

It was noted that future meetings of the Board would be held on the following dates:-

Thursday 15th December 2016 – 5.00pm
Monday 6th February 2017 – 3.00pm
Monday 3rd April 2017 – 2.00pm

Meetings of the Board were scheduled to be held in Meeting Room G01 at City Hall unless stated otherwise on the agenda for the meeting.

35. ANY OTHER URGENT BUSINESS

There were no items to be considered.

36. CLOSE OF MEETING

The Chair declared the meeting closed at 4.35pm.